Georgia Department of Behavioral Health & Developmental Disabilities

Kevin Tanner, Commissioner

Division of Strategy, Technology, & Performance

APPLICATION FOR ERET DESIGNATION

☐ NEW APPLICATION ☐ ANNUAL APPLICATION	Date of Application:	

FACILITY INFORMATION

Name of Facility:	
Address: (Street, City, Zip)	
County:	
Governing Authority / Owner:	
Facility Type:	☐ Psychiatric Hospital ☐ Acute Care Hospital with Psychiatric Unit ☐ Acute Care Hospital without Psychiatric Unit

Accreditation / License *(If new application, please provide a copy of the license)*	
Accrediting / Licensing Organization	Expiration Date

Psychiatrist *(for Evaluating and Treatment Facilities)*	
Name:	
Georgia License Number:	
Board Certification(s):	
Experience / Other Qualifications:	

Contact Person	
Name:	
Title:	
Email:	
Phone Number:	

DESIGNATION TYPE: (CHECK ALL THAT APPLY)

☐ **E**mergency **R**eceiving ☐ **E**valuating ☐ **T**reatment **F**acility

Note: A separate Application for ERET Designation must be submitted for each facility / location.

POPULATION SERVED

Adult			Child & Adolescent	
# of Beds:			# of Beds:	
Age Range:			Age Range:	
Service Description:			Service Description:	

ATTESTATION:

Note: Initial each statement below

	This facility is in compliance with the requirements pertaining to emergency receiving, evaluation and treatment facilities State of Georgia Rules and Regulations for Hospitals chapter 111-8-40-.37 and Guidelines for the Design and Construction of Hospitals and Healthcare Facilities.
	This facility will provide only those emergency receiving, evaluation and treatment services for which it has received prior approval.
	The addition of any category / designation requires approval from DBHDD.
	This facility is in compliance with the CMS regulations and accrediting body standards.
	Any CMS or accrediting body report with findings regarding Emergency Receiving, Evaluation and Treatment related services will be forwarded to DBHDD within 30 days. ***(Please provide a copy of the latest report.)***
	Any Corrective Action Plan regarding Emergency Receiving, Evaluation and Treatment related services will be forwarded to DBHDD within 30 days. ***(Please provide any current/in process Corrective Action Plan.)***

Administrator / CEO:	Name:
	Title:
	Email:
	Signature:
	Date:

Submit form via email to: Provider.Certification@dbhdd.ga.gov